| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED | | | |
|--|----------------------|---|-------------|--|--------------------|
| AND PLAN | OF CORRECTION | 155782 | A. BUILDING | 00 | 10/07/2011 |
| | | .557.52 | B. WING | ADDRESS CITY STATE ZID CODE | . 5, 5 / 1 / 2 / 1 |
| NAME OF F | PROVIDER OR SUPPLIEF | R | 814 S 6 | ADDRESS, CITY, STATE, ZIP CODE | |
| WHITE C | OAK HEALTH CAM | PUS | | CELLO, IN47960 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F0000 | | | | | |
| | This visit was fo | r a Recertification and | F0000 | | |
| | State Licensure s | | | | |
| | | , | | | |
| | Survey Dates: C | October 4, 5, 6, 7, 2011 | | | |
| | Facility Number | : 012355 | | | |
| | Provider Numbe | | | | |
| | AIM Number: 2 | 201014410 | | | |
| | | | | | |
| | Survey Team: | | | | |
| | Linda Campbell, | , RN, TC | | | |
| | Christi Davidsor | n, RN | | | |
| | Courtney Hamilt | ton, RN (October 4 & 5, | | | |
| | 2011) | | | | |
| | | | | | |
| | Census Bed Typ | e: | | | |
| | SNF/NF: | 7 | | | |
| | SNF: 29 | | | | |
| | | 34 | | | |
| | Total: 70 | | | | |
| | Census Payor Ty | /ne· | | | |
| | Medicare: 21 | , k. | | | |
| | Medicaid: 7 | | | | |
| | Other: 42 | | | | |
| | Total: 70 | | | | |
| | | | | | |
| | Sample: 10 | | | | |
| | Supplemental: 4 | | | | |
| | Residential Sam | ple: 9 | | | |
| | | | | | |
| | These deficienci | es also reflect state | | | |
| LABORATOR | Y DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S SI | GNATURE | TITLE | (X6) DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G2ED11

Facility ID:

012355

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | |
|--|------------------------------|---|---|---------------|--|----------|--------------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 155782 | B. WING | | | 10/07/20 | 011 |
| | | | F | | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | - | | 814 S 6 | TH ST | | |
| | AK HEALTH CAMP | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | * | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | COMPLETION DATE |
| IAG | | | | IAG | | | DATE |
| | | accordance with 410 IAC | | | | | |
| | 16.2. | | | | | | |
| | 0 10 | 1 . 110/10/11 | | | | | |
| | · · · | ompleted 10/12/11 | | | | | |
| | Cathy Emswiller | | | | | | |
| F0279 | A facility must use | | | | | | |
| SS=D | | velop, review and revise the nensive plan of care. | | | | | |
| | 1 2 0.00 0 0 0 0 1 1 p 1 0 1 | | | | | | |
| | | evelop a comprehensive | | | | | |
| | • | resident that includes | | | | | |
| | - | tives and timetables to meet al, nursing, and mental and | | | | | |
| | | ds that are identified in the | | | | | |
| | comprehensive as | | | | | | |
| | · | | | | | | |
| | • | st describe the services that | | | | | |
| | | d to attain or maintain the practicable physical, | | | | | |
| | _ | osocial well-being as | | | | | |
| | | 83.25; and any services that | | | | | |
| | | e required under §483.25 | | | | | |
| | • | ed due to the resident's | | | | | |
| | | under §483.10, including the | | | | | |
| | | atment under §483.10(b)(4). | F02 | 770 | Corrective actions accomplis | hed | 11/06/2011 |
| | | e facility failed to ensure | 1 102 | 213 | for those residents found to h | | 11/00/2011 |
| | , i | • | | | been affected by the alleged | | |
| | • | applated related to | | | deficient practice:Care plans | | |
| | • | plemented to prevent falls | | | been updated for Residents and #30 to reflect intervention | | |
| | | ents with care plans in a | | | related to falls. Identification | | |
| | sample of 10. (R | esidents #23 and #30). | | | other reidentshaving the pote | | |
| | D' 1' ' 1 1 | | | | to be affected by the same | | |
| | Findings include | : | | | alleged deficient practice and | i | |
| | | | | | corrective action taken:All residents assessed at risk for | r falle | |
| | | clinical record was | | | or residents who have fallen | | |
| | | 5/11 at 9:15 A.M. The | | | been identified as having the | | |
| | record indicated | the resident had fallen on | | | potential to be affected. Care | , | |
| | | | | | plans have been reviewed ar | nd | |

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | LDING | NSTRUCTION 00 | | E SURVEY LETED 2011 |
|--------------------------|---|--|----------|---------------------|---|-------|----------------------------|
| | PROVIDER OR SUPPLIER | | <u> </u> | 814 S 6 | DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN47960 | E | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| | cushion in the wl | as a trial of a wedge heelchair. The resident the been updated with that | | | | | |
| | recommended we hours, nonskid for parameter mattre mats to floor in r | ditional interventions ere toilet every two botwear, low bed, defined ess, motion detector, and boom. The resident care dated with the low bed ther additional | | | | | |
| | recommended we and a trial of a se | litional interventions ere dycem in wheelchair elf release seatbelt. The n had not been updated to erventions. | | | | | |
| | recommended we alarm and move resident's reach. | litional interventions ere replace batteries in the alarm box out of The resident care plan lated to include those | | | | | |
| | recommended we diversional activand increase amo | resident care plan had | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G2ED11 Facility ID:

012355

If continuation sheet

Page 4 of 47

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MU A. BUIL B. WING | LDING | NSTRUCTION 00 | (X3) DATE (COMPL 10/07/20 | ETED | |
|--|--|--|-------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | | 814 S 6 | DDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| TAG | 9/24/11 - docume care plan was lace additional interverse after the fall. Interview on 10/2 the Director of Normal plan had not been interventions after the en updated. 2. The record for reviewed on 10/2 to hip joint replay disorders due to anxiety, and seni uncomplicated. The facility Asset Considerations do "This resident factors that may falls:Medical continuity in address the about minimize the rish the likelihood of the admission Medical of the admissio | entation on the resident sking related to any entions recommended 5/11 at 10:15 A.M. with fursing indicated the care in updated with er falls and should have r Resident #23 was 05/11 at 12:45 p.m. ded, but were not limited cement, persistent mental condition, hypertension, le dementia essment Review and ated 04/06/11 indicated, has the following risk contribute to ondition/diagnosisAn are plan has been initiated ove risk factors and cof falling and/or reduce | | TAG | | | DATE |
| | Resident #23 had | l severe vision | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | A. BUIL | DING | NSTRUCTION 00 | (X3) DATE COMPL 10/07/2 | ETED | |
|--|--|---|---------|----------------|--|------|--------------------|
| | | | B. WING | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 2 | | 814 S 6 | | | |
| | OAK HEALTH CAMI | | | MONTIC | CELLO, IN47960 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | · | ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | DATE |
| | | e MDS indicated Resident | | | | | |
| | #23 was not oriented to year or day of the | | | | | | |
| | | ed "blue" and "bed" with | | | | | |
| | cueing. Residen | t #23's total cognitive | | | | | |
| | score was a 7 ou | t of a possible 15, | | | | | |
| | indicating the res | sident was severely | | | | | |
| | impaired in cognitive decision-making skills. The MDS indicated Resident #23 was an | | | | | | |
| | | | | | | | |
| | extensive assist with two person physical | | | | | | |
| | assist for transfer and toilet use. The | | | | | | |
| | MDS indicated the resident was not | | | | | | |
| | steady moving on and off the toilet and | | | | | | |
| | | assistance to stabilize. | | | | | |
| | | | | | | | |
| | _ | d, "Falls," dated 04/20/11 | | | | | |
| | - | sk for fall/injury AEB [as | | | | | |
| | evidenced by] H | - | | | | | |
| | | on usagepainResident | | | | | |
| | | d risk of fall related | | | | | |
| | | g precautionsUse fall | | | | | |
| | risk assessment t | alls to MD/responsible | | | | | |
| | | or side effects of any drug | | | | | |
| | 1 1 1 - | ait disturbance, orthostatic | | | | | |
| | _ | akness, sedation, vertigo, | | | | | |
| | | l statusReport to MD | | | | | |
| | _ | e effects associated with | | | | | |
| | | tion use Provide | | | | | |
| | | daptations:Half rails as | | | | | |
| | enabler_Call lig | • | | | | | |
| | | nonitor use of adaptive | | | | | |
| | devices:Wheel | _ | | | | | |
| | | | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ULTIPLE CO LDING | INSTRUCTION 00 | (X3) DATE COMPL | |
|---------------|--|--|------------------|---------------------|--|--------------------|--------------------|
| | | 155782 | A. BUI B. WIN | | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | 2 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 814 S 6 | | | |
| WHITE C | OAK HEALTH CAMI | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | * | ICY MUST BE PERCEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) A purpose note dated 04/28/11 at 7:05 p.m. | | | IAG | | | DATE |
| | A nurses note dated 04/28/11 at 7:05 p.m. indicated, "writer observed res | | | | | | |
| | | on the floor to [left] side | | | | | |
| | 1 2 2 2 | RCA [certified resident | | | | | |
| | care aide] was pr | • | | | | | |
| | | for and reported that | | | | | |
| | 1 | ll. CRCA stated that res | | | | | |
| | | o wipe self [sign for | | | | | |
| | | hifted weight on toilet | | | | | |
| | riser, then fell to floorStaff unable to | | | | | | |
| | move ressevere [sign for left] hip pain." | | | | | | |
| | | | | | | | |
| | A nurses note dated 04/28/11 at 7:50 p.m. | | | | | | |
| | indicated, "en | (sic) route toER | | | | | |
| | [emergency roor | n]." | | | | | |
| | | | | | | | |
| | | ance, Assessment and | | | | | |
| | | n dated 04/28/11 at 7:05 | | | | | |
| | p.m. indicated re | | | | | | |
| | bathroom, and C | | | | | | |
| | | time of the fall. The fall | | | | | |
| | | nt questions included, but | | | | | |
| | | to, "Resident has | | | | | |
| | - | mory impairment that | | | | | |
| | | d judgement?" This | | | | | |
| | _ | "yes." "Resident has tanding and following | | | | | |
| | 1 | is question marked "no." | | | | | |
| | | es assistance to transfer?" | | | | | |
| | ^ | arked "yes." "Resident is | | | | | |
| | | in balance while sitting, | | | | | |
| | | ing without assistance?" | | | | | |
| | _ | arked "yes." "Resident | | | | | |
| | • | y with safety measures | | | | | |
| | Liciuses to compi | y with safety incasules | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G2ED11 Facility ID: 012355

If continuation sheet

Page 7 of 47

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | LDING | NSTRUCTION 00 | COM | te survey IPLETED 1/2011 |
|--------------------------|--|---|--------|---------------------|--|-------------------------------|--------------------------------|
| | PROVIDER OR SUPPLIEF | | B. WIN | STREET A 814 S 6 | DDRESS, CITY, STATE, ZII TH ST CELLO, IN47960 | P CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| | such as call light etc?" This quest written note that forgets." The pr the toilet riser re [interdisciplinary indicated. The fall care pla of an updated into A nurses note da [12:20 p.m.] indicated [2:20 p.m.] indicated [5:00 a.m.] indicated [5:00 a.m.] indicated [6:00 p.m.] indicated [6:00 p.m.] indicated [4:00 a.m.] | use, alarms, appliances, ion marked "yes" with a indicated, "often evention update indicated | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | 00 | COMPI | | |
|---|-----------------------------------|---|--------|---------------|--|------------|--------------------|
| 11112 12111 | or condition | 155782 | | LDING | | 10/07/2011 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | 814 S 6 | | | |
| WHITE C | DAK HEALTH CAM | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | * | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | COMPLETION DATE |
| 1710 | | ssessment questions | | 1710 | <u> </u> | | DATE |
| | included, but we | * | | | | | |
| | - | gnitive or memory | | | | | |
| | | effects safety and | | | | | |
| | • | is question marked "no." | | | | | |
| | ٠ | fficulty understanding | | | | | |
| | | rections?" This question | | | | | |
| | marked "no." "F | • | | | | | |
| | | nsfer?" This question | | | | | |
| | marked "yes." " | Resident is unable to | | | | | |
| | maintain balance | while sitting, standing or | | | | | |
| | walking without assistance?" This | | | | | | |
| | question marked | "no." "Resident refuses | | | | | |
| | to comply with s | afety measures such as | | | | | |
| | call light use, ala | rms, appliances, etc?" | | | | | |
| | This question ma | arked "no." The | | | | | |
| | prevention updat | te indicated resident was | | | | | |
| | educated on call | light usage. No IDT | | | | | |
| | | team] recommendations | | | | | |
| | indicated. | | | | | | |
| | The "Fall" care p | olan was updated on | | | | | |
| | • | ded "hipsters" as an | | | | | |
| | intervention. | | | | | | |
| | An MDC data d | 07/03/11 indicated | | | | | |
| | | | | | | | |
| | | severely impaired vision. ted Resident #23 did not | | | | | |
| | | year, and recalled "blue" | | | | | |
| | and "bed" with c | - | | | | | |
| | | was an 8 out of a possible | | | | | |
| | _ | e resident was moderately | | | | | |
| | , | itive decision-making | | | | | |
| | | S indicated the resident | | | | | |
| | SKIIIS. THE MIDS | marcated the resident | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G2ED11 Facility ID:

012355

If continuation sheet

Page 9 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | | LDING | NSTRUCTION 00 | (X3) DATE : COMPL 10/07/2 | ETED | |
|--|---|--|---------|----------------|--|------|--------------------|
| | | <u> </u> | S. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 814 S 6 | | | |
| | OAK HEALTH CAM | | | <u> </u> | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| TAU | | · · · · · · · · · · · · · · · · · · · | | TAG | | | DATE |
| | _ | n physical assist to et. The MDS indicated | | | | | |
| | | s not steady and needed | | | | | |
| | | e to stabilize to do | | | | | |
| | | s moving on and off toilet. | | | | | |
| | detivities such as | inoving on and on tonet. | | | | | |
| | A nurses note da | ted 09/19/11 at 0900 | | | | | |
| | [9:00 a.m.] indic | ated, "CRCAfound | | | | | |
| | res laying on her | back on the bathroom | | | | | |
| | floor. Res stated, 'I forgot to get my | | | | | | |
| | walker and walked in here without itres | | | | | | |
| | very tearfultail | bone painRes bed was | | | | | |
| | wet as well as he | er hipsters were lying on | | | | | |
| | bed wet. When | asked if she took them off | | | | | |
| | res stated, 'yes, I | had to they are | | | | | |
| | wet.'report call | ed tohospital ER." | | | | | |
| | A nurses note da | ted 09/19/11 at 1140 | | | | | |
| | | cated, "Res returned from | | | | | |
| | hospital[sign fo | or no] new orders" | | | | | |
| | A Fall Circumsta | ance Investigation dated | | | | | |
| | 09/19/11 at 0900 | [9:00 a.m.] indicated, | | | | | |
| | "Res transferre | ed self and ambulated to | | | | | |
| | | or without] walker by | | | | | |
| | self" The fall | risk re-assessment | | | | | |
| | - | ed, but were not limited | | | | | |
| | | cognitive or memory | | | | | |
| | _ | effects safety and | | | | | |
| | ر ت | is question marked "yes." | | | | | |
| | | fficulty understanding | | | | | |
| | _ | rections?" This question | | | | | |
| | marked "no." "F | _ | | | | | |
| | assistance to trar | sfer?" This question | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MU A. BUIL B. WING | LDING | NSTRUCTION 00 | (X3) DATE S COMPL 10/07/20 | ETED | |
|--|--|---|-------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | | STREET A 814 S 6 | DDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | maintain balance walking without question marked to comply with seall light use, ala This question may prevention update [wheelchair] safetimportance of walker. The "Fall" care prindicated, "edu walker." On 10/06/11 at 1 was observed lay eyes closed. The was positioned as bed. During an interval.m., Certified Fall (CRCA) #2, indicated transferred self for and to the toilet. The resident called for resident's brief in does not call for indicated the resident's see her was "can't | olan update on 09/19/11 lication on Res using 0:55 a.m. Resident #23 lying on her bed with her le resident's wheelchair t the foot of the resident's liew on 10/06/11 at 10:56 Resident Care Aide licated Resident #23 lying on her bed with her le resident's wheelchair t the foot of the resident's I would be the sident for a sistance if the licated changed, otherwise licated changed, otherwise licated has poor vision and | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|--------------------------------|--------|----------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155782 | B. WIN | G | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIEI | 3 | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF I | ROVIDER OR SOLITEIE | X. | | 814 S 6 | | | |
| WHITE OAK HEALTH CAMPUS | | | | MONTI | CELLO, IN47960 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENC!) | | DATE |
| | | dicated Resident #23 was | | | | | |
| | listed as an assist of 1 on the daily | | | | | | |
| | assignment shee | t under mobility. | | | | | |
| | On 10/06/11 at 1 | 12:40 p.m., the Executive | | | | | |
| | | ed the daily assignment | | | | | |
| | ^ | nt #23 for 10/06/11. | | | | | |
| | Sheet for Reside. | 101 10/00/11. | | | | | |
| | The daily assign | ment sheet dated | | | | | |
| | , , | 5 a.m. indicated resident | | | | | |
| | #23 was an assis | st of 1 for mobility. | | | | | |
| | | , | | | | | |
| | During an interv | riew on 10/06/11 at 1:40 | | | | | |
| | - | or of Health Services | | | | | |
| | (DHS) indicated | she assisted the CRCA | | | | | |
| | on 04/28/11 to p | out Resident #23 on the | | | | | |
| | toilet. She indic | ated the toilet riser was | | | | | |
| | loose. She indic | eated documentation does | | | | | |
| | not always reflec | ct when two person | | | | | |
| | transfers or assis | sts are used. DHS | | | | | |
| | indicated the int | ervention was to replace | | | | | |
| | the riser and bol | t it down. She indicated | | | | | |
| | the intervention | was not reflected on the | | | | | |
| | care plan becaus | se it was environmental. | | | | | |
| | DHS indicated F | Resident #23 was taking | | | | | |
| | self to bathroom | . DHS indicated, "She | | | | | |
| | has come a long | way." DHS indicated | | | | | |
| | _ | ent reminders and | | | | | |
| | _ | to use walker and call | | | | | |
| | light. | | | | | | |
| | | | | | | | |
| | A policy provide | ed by the DHS on | | | | | |
| | 10/05/11 at 1:10 | p.m. titled, "Fall/Safety | | | | | |
| | Management Ed | ucational Information," | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | | LDING | NSTRUCTION 00 | | (X3) DATE COMPL 10/07/2 | ETED |
|---------------|---|---|--------|---------------|---|--------------------|-------------------------------|--------------------|
| | | | D. WIN | | ADDRESS, CITY, STATI | E, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | R | | 814 S 6 | | , | | |
| WHITE C | OAK HEALTH CAME | PUS | | MONTIC | CELLO, IN47960 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | | N OF CORRECTION | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE A CROSS-REFERENCED DEFICII | TO THE APPROPRIAT | ΓE | COMPLETION DATE |
| TAG | | ves to maintain a hazard | | TAG | <i>B2.</i> 10. | | | DATE |
| | • | t, mitigate fall risk factors | | | | | | |
| | and implement p | • | | | | | | |
| | | fall Circumstance and | | | | | | |
| | | orm'includes the | | | | | | |
| | | | | | | | | |
| | | sic) of the circumstances | | | | | | |
| | _ | fall to determine the ode, a reassessment to | | | | | | |
| | • | | | | | | | |
| | | contributing factors, reduce risk of repeat | | | | | | |
| | episode and a rev | - | | | | | | |
| | • | y team] to evaluate | | | | | | |
| | | the investigation and | | | | | | |
| | _ | of the interventionsIt is | | | | | | |
| | * * * | scover, 'what the resident | | | | | | |
| | - | at the time of the fall.'If | | | | | | |
| | | as been tried, but falls | | | | | | |
| | still occur, move | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | · · | rior one has not been | | | | | | |
| | _ | nuing current plan=expect | | | | | | |
| | | ange plan=expect | | | | | | |
| | | Interventions should be | | | | | | |
| | | me a 'risk' is identified, | | | | | | |
| | | all occurs" The policy | | | | | | |
| | | e interventions for least | | | | | | |
| | _ | erately restrictive and | | | | | | |
| | highest restrictiv | • | | | | | | |
| | inghest restrictiv | C . | | | | | | |
| | 3.1-35(a) | | | | | | | |
| | 5.1 55(u) | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| FORM CMS-2 | 567(02-99) Previous Version | ons Obsolete Event ID: (| | Facility I | D: 012355 | If continuation sh | neet Pa | ge 13 of 47 |

| i i i i i i i i i i i i i i i i i i i | | X1) PROVIDER/SUPPLIER/CLIA | | | | (X3) DATE | SURVEY |
|---------------------------------------|---------------------------------------|---|--------------|--------------------------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155782 | B. WIN | | | 10/07/2 | 011 |
| | | | B. WIIV | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 814 S 6 | | | |
| WHITE O | OAK HEALTH CAME | PUS | | | CELLO, IN47960 | | |
| | | | 1 | | 52226, HTT 555 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | | | | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | | DATE |
| F0323 | • | nsure that the resident ins as free of accident | | | | | |
| SS=D | | sible; and each resident | | | | | |
| | receives adequate supervision and a | | | | | | |
| | devices to prevent | | | | | | |
| | Based on observa | ation, interview, and | F0 | 323 | Corrective actions accomplis | | 11/06/2011 |
| | record review, th | e facility failed to | | | for those residents found to h | nave | |
| | - | rentions to prevent falls | | | been affected by the alleged | | |
| | - | its with falls in a sample | | | deficient practice:Intervention have been implemented to | เร | |
| | of 10. (Residents | _ | | | prevnet falls following comple | etion | |
| | or to. (Residents | $\pi 23 \text{ and } \pi 30$). | | | of risk assessment for Resident | | |
| | E' 1' ' 1 1 | | | | #23 and #30Identification of | other | |
| | Findings include | : | | | residents having t potential to | | |
| | | | | | affected by the same alleged | | |
| | | 8:00 A.M., with the | | deficient practice and correct | | | |
| | Director of Nursi | ing, Resident #30 was | | | actions taken:All residents assessed at risk for falls or | | |
| | identified as havi | ing had several falls. The | | | residents who have fallen ha | ve | |
| | last fall was "last | week." The resident was | | | been identified as having the | | |
| | identified as havi | ing a bed and chair alarm | | | potential to be affected. | | |
| | in place. | | | | Interventions have been | | |
| | F | | | | implemented to prevent falls | | |
| | On 10/5/11 at 0:1 | 15 A.M., Resident #30 | | | following completion of risk | 4 :4 | |
| | | | | | assessements. Measures pu place and systemic change r | | |
| | - | ng in bed in her room. | | | to ensure the alleged deficien | | |
| | | ow position. The alarm | | | practice does not recur:Each | | |
| | | on the side rail next to | | | admission is assessed for fa | | |
| | | d. The wheelchair was | | | with approproate itervention | | |
| | _ | re were no mats on the | | | intitiated for prevention. Follo | | |
| | floor. There was | no motion sensor in the | | | each fall the resident is asse | ssed | |
| | room. There was | no dycem in her | | | with interdisciplinary approach and intervention ar | nd | |
| | wheelchair. | | | | care plan updated to reflect | | |
| | | | | | current interventions. How th | е | |
| | Interview on 10/2 | 5/11 at 10:00 A.M. with | | | corrective actions will be | | |
| | the Director of Nursing indicated the | | | | monitored to ensure the alleg | ged | |
| | | alarms on the bed. | | | deficient practice does not | | |
| | | ne time of the interview | | | recur:DHS or designee is | on for | |
| | | | | | reviewing each new admission fall risk assessment and | ווע ווע | |
| | indicated there w | as only one alarm being | | | ומוו וואר מאשטאאוווכוונ מווע | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S COMPL | | |
|--|---|--|------------|--|---|---|------------|
| AND PLAIN | OF CORRECTION | 155782 | | LDING | 00 | 10/07/2 | |
| | | 100702 | B. WIN | | DDDEGG CITY CTATE 7ID CODE | 10/01/2 | 311 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 814 S 6 | DDRESS, CITY, STATE, ZIP CODE | | |
| WHITE C | OAK HEALTH CAME | PUS | | | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | | | DATE |
| TAG | Resident #30's cl reviewed on 10/5 record indicated with diagnoses w not limited to, ce (stroke), weakned. A Minimum Data Assessment dated resident was more cognitive decision extensive one-perfor transfer and to one-person physical ambulation, was to stabilize with balance, and had A "Physical Their dated 2/14/11 incidemonstrated a sufficient functional transfer care tasksGait (moderate assistations) | inical record was 5/11 at 9:15 A.M. The the resident was admitted which included, but were rebrovascular accident ss, and dementia. a Set (MDS) Quarterly d 8/12/11 indicated the derately impaired in on-making skills, required reson physical assistance oilet use, required limited ical assistance for not steady and only able human assistance for fallen. rapy Initial Plan of Care" dicated "has ignificant decline in ers, mobility, and selfAssistance: Mod A ance) to Max A tance)TransfersBed | | TAG | approproate interventon implemented as well as revie each resident's medical reco following a fall for appropriate current interventions and upocare plan. All monitoring resu will be reported each month QA committee x 7 months for review and evaluation of effectiveness. All corrective actions will be completed by 11/6/11. | ewing rd e and dated ults to | DATE |
| | AWheelchair < | <-> Commode: Mod | | | | | |
| | ABalanceStatic Standing: | | | | | | |
| | FairDynamic Standing: FairFall | | | | | | |
| | riskHighSafety AwarenessPoor" | | | | | | |
| | A resident care p | olan dated 3/3/11 | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 10/07/2 | LETED | |
|--|--|---|----------|---------------------|---|-------|----------------------------|
| | OF PROVIDER OR SUPPLIE | | _ | 814 S 6 | | | |
| WHIT | E OAK HEALTH CAM | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE . | (X5) COMPLETION DATE |
| | AEB (as evidence (indicated by checkmark)InternablerCall light free of clutterWheeled resident to reque ambulationbech alarmHigh/low bed" A "Monthly Num Collection" form "SafetyHistor (Yes-circled)F and/or forgets to (circled)Non-comeasures? Y (circled)monitor for impute as appropriate transfer" A nurses' notes of indicated "Res (ambulating from (Certified Residualarm & observed c (with) bilat (bit (right) sideAlarete of the control of th | Requires assistive devices | | | | | |

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155782 | | ĺ | LDING | NSTRUCTION 00 | (X3) DATE COMPL 10/07/2 | ETED | |
|--|---|--|-------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIEF | | | 814 S 6 | ODDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Intervention" for P.M. indicated ". (circled)Found time of fall:Tra by X)Family p (room) & Res haneedsSafety eq functioning at tir (circled)Wheel (circled)Wheel (circled)Prever Ensure w/c brake chair alarmHad tabs alarm applicational recomposition of a part of the property of th | es locked and the pressure alarm after the atted 4/1/11 at 6:00 P.M. was self transferring self to (with) nonskid shoes. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | | LDING | NSTRUCTION 00 | COM | ie survey ipleted 7/2011 | |
|--|--|---|---------|---------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | p. wiiv | STREET A 814 S 6 | DDRESS, CITY, STATE, ZIF TH ST CELLO, IN47960 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| | (circled)Found time of fall:Tra by X)Safety ed functioning at tin (circled). Res too brakes locked? NupdateFrequer reachOrient to Ensure w/c brake chair alarmAla w/c" Docume for the IDT (intereview. There w recommendation A resident care pupdated to indicaused items within alarm on the bot after the 4/1/11 fall A nurses' note da Resident observed bed. CRCA hear assistw/c brake A "Fall Circums Intervention" for P.M. at indicated (circled)Found time of fall:Tra by X)Toileting | olan dated 3/3/11 was not ate to keeping frequently in reach and placing the tom of the wheelchair fall. ated 4/5/11 at 6:50 P.M. " ed on floor beside w/c & d w/c alarm & went to | | | | | |

012355

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE : COMPL | | |
|--|--|------------------------------|------------|-------------|--|---------|------------|
| AND PLAN | OF CORRECTION | 155782 | | LDING | 00 | 10/07/2 | |
| | | 133702 | B. WIN | | | 10/01/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 814 S 6 | ADDRESS, CITY, STATE, ZIP CODE | | |
| WHITE C | OAK HEALTH CAME | PUS | | | CELLO, IN47960 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | ne of incident? Y (Yes) | | | | | |
| | (circled)Wheelchair brakes locked? Y (circled)Prevention UpdateTherapy | | | | | | |
| | | | | | | | |
| | | bellchair alarm | | | | | |
| | (circled)Wedge | | | | | | |
| | Documentation i | | | | | | |
| | 1 ` 1 | team) review was done | | | | | |
| | on 4/6/11. There | were no additional | | | | | |
| | recommendation | s after the 4/6/11 fall. | | | | | |
| | | 1 1 2 2 2 2 2 2 | | | | | |
| | _ | lan dated 3/3/11 was not | | | | | |
| | | ate the use of a wedge | | | | | |
| | | 4/5/11 fall. An undated | | | | | |
| | entry indicated " | Sensor alarm by bed" | | | | | |
| | A "Fall Circumst | ance Assessment and | | | | | |
| | Intervention" for | m dated 4/24/11 at 10:45 | | | | | |
| | P.M. indicated ". | Witnessed: N (no) | | | | | |
| | (circled)Found | on floorActivity at | | | | | |
| | time of fall:Toil | leting (indicated by | | | | | |
| | X)Toileting ne | eds (indicated by | | | | | |
| | X)Safety equip | ment in place and | | | | | |
| | | ne of incident? Y | | | | | |
| | (circled)Res ab | le to turn off motion | | | | | |
| | , , | on UpdateToilet q2h | | | | | |
| | (every two hours | | | | | | |
| | footwearLow b | pedDefined parameter | | | | | |
| | mattressbed an | d/or chair alarmBed in | | | | | |
| | low positionMe | otion detectorMats to | | | | | |
| | floor in roomB | rought to nurses | | | | | |
| | station" Docum | nentation indicated the | | | | | |
| | IDT (interdiscipl | inary team) review was | | | | | |
| | done on 4/25/11. | | | | | | |
| | indicated "IDT re | eview of above | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G2ED11 Facility ID:

012355

If continuation sheet

Page 19 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|---|------------------------------|-------------------|----------------|---|---------|------------|
| | | 155782 | A. BUII B. WIN | LDING | | 10/07/2 | |
| | | | D. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | 814 S 6 | | | |
| WHITE (| OAK HEALTH CAMI | PUS | | MONTI | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | regulatory or LSC identifying information) prevention update agrees as appropriate to | | | TAG | DEFICIENC!) | | DATE |
| | maximize safetyY (circled)" | | | | | | |
| | A resident care p | plan dated 3/3/11 was not | | | | | |
| | updated to indica | ate the resident should be | | | | | |
| | toileted every tw | o hours, the use of a | | | | | |
| | defined parameter | er mattress, or mats on the | | | | | |
| | floor after the 4/ | 24/11 fall. | | | | | |
| | A nurses' note da | ated 5/15/11 at 7:20 A.M. | | | | | |
| | indicated "CRCA | A summoned writer to | | | | | |
| | (room number) v | where res was observed | | | | | |
| | ` ′ | ks on floor by bedside in | | | | | |
| | front of w/c. W/c | C pad alarm was | | | | | |
| | sounding which | had alerted staff of res (I) | | | | | |
| | (independent) tra | ansfer et (and) fall. Res | | | | | |
| | stated 'I was tryi | ng to get into bed.'Res | | | | | |
| | has dx (diagnosi | s): dementia et lacks | | | | | |
| | safety awareness | s. Res failed to ask staff | | | | | |
| | for assistance" | | | | | | |
| | A "Fall Circums | tance Assessment and | | | | | |
| | | rm dated 5/15/11 at 7:20 | | | | | |
| | | Witnessed: N (no) | | | | | |
| | | on floor. W/c alarm | | | | | |
| | soundedActivi | ty at time of | | | | | |
| | fall:Transferrin | g self (indicated by | | | | | |
| | X)Res stated 'I | was trying to get into | | | | | |
| | bed'Safety equ | ipment in place and | | | | | |
| | functioning at time of incident? Y (Yes) | | | | | | |
| | (circled)Wheelchair brakes locked? N | | | | | | |
| | (circled)Prevention UpdateBed and/or | | | | | | |
| | chair alarmdic | em (sic) replace in | | | | | |
| | w/cwill trial s | elf release seatbelt" | | | | | |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
|---------------|---|--|--------|---------------|--|-----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155782 | B. WIN | G | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIEI | ? | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| \\/\ UTC (| | DLIC | | 814 S 6 | | | |
| | OAK HEALTH CAM | | | MONTI | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | * | ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| IAG | † | indicated the IDT | | IAG | , | | DATE |
| | | y team) review was done | | | | | |
| | | umentation indicated | | | | | |
| | | above prevention update | | | | | |
| | | oriate to maximize | | | | | |
| | safetyY (circle | | | | | | |
| | Saicty1 (circle | ли <i>ј</i> | | | | | |
| | A resident care | plan dated 3/3/11 was not | | | | | |
| | _ | ate the use of dicem (sic) | | | | | |
| | * | r or the use of a self | | | | | |
| | | after the 5/15/11 fall. | | | | | |
| | release seatoen after the 3/13/11 fair. | | | | | | |
| | A nurses' note dated 5/30/11 at 6:45 P.M. | | | | | | |
| | indicated "CR | CA informed writer Res | | | | | |
| | was noted being | on floor beside bed. Res | | | | | |
| | _ | to transfer out of bed into | | | | | |
| | | v/t (within) reach & not | | | | | |
| | turned onBed | ` ' | | | | | |
| | disconnected" | | | | | | |
| | | | | | | | |
| | A "Fall Circums | tance Assessment and | | | | | |
| | Intervention" for | rm dated 5/30/11 at 7:00 | | | | | |
| | P.M. indicated " | Witnessed: N (no) | | | | | |
| | (circled)Found | l on floorActivity at | | | | | |
| | time of fall:Tra | insferring self (indicated | | | | | |
| | by X)Improper | r or ill fitting footwear | | | | | |
| | (indicated by X) | Safety equipment in | | | | | |
| | place and function | oning at time of incident? | | | | | |
| | |)Res was in bed & took | | | | | |
| | batteries our of a | alarmPrevention | | | | | |
| | UpdateCall bellBed and/or chair | | | | | | |
| | alarmBatteries | replaced & box | | | | | |
| | moved" Docur | mentation indicated the | | | | | |
| | IDT (interdiscip | linary team) review was | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/G AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X1) PROVIDER/SUPPLIER/CLIA | (X2) |) MULTIPLE CO | | | X3) DATE | |
|--|---|---------------------------------------|------|---------------|-------------------|---|----------|-------------|
| AND PLAN | OF CORRECTION | | А. В | BUILDING | 00 | | COMPL | |
| | | 155782 | B. W | VING | | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | 3 | | | ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| MUUTE C | NA 14 1 15 A 1 TH 1 O A B 45 | DU O | | 814 S 6 | | • | | |
| WHITE | OAK HEALTH CAMP | PUS | | MONTIO | CELLO, IN4796 | 0 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | | PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | ICY MUST BE PERCEDED BY FULL | | PREFIX | CROSS-REFERENC | VE ACTION SHOULD BE ED TO THE APPROPRIAT | E | COMPLETION |
| TAG | done on 6/1/11. Documentation indicated | | | TAG | DEF | FICIENCY) | | DATE |
| | | | | | | | | |
| | | above prevention update | | | | | | |
| | | riate to maximize | | | | | | |
| | safetyY (circle | ed)" | | | | | | |
| | | | | | | | | |
| | _ | olan dated 3/3/11 was not | | | | | | |
| | updated to indica | ate ensuring batteries | | | | | | |
| | were in the alarm | n box and moving the | | | | | | |
| | alarm box after the | the 5/30/11 fall. | | | | | | |
| | | | | | | | | |
| | A "Monthly Nurs | rsing Assessment & Data | | | | | | |
| | Collection" form | dated 6/6/11 indicated | | | | | | |
| | "CognitionST (| (short term) memory | | | | | | |
| | deficits/unable to | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | | Alarming velcro | | | | | | |
| | beltHistory of t | | | | | | | |
| | 1 | equires assistive devices | | | | | | |
| | and/or forgets to | • | | | | | | |
| | " | compliant with safety | | | | | | |
| | , , | rcled)Can remove safety | | | | | | |
| | ` | • | | | | | | |
| | | I't prevent from previous | | | | | | |
| | act? Y (circled) | | | | | | | |
| | | are plan has been initiated | | | | | | |
| | | risk of falling and/or | | | | | | |
| | | hood of injuryContinue | | | | | | |
| | current plan" | | | | | | | |
| | | | | | | | | |
| | | tance Assessment and | | | | | | |
| | | rm dated 6/6/11 at 4:15 | | | | | | |
| | | Witnessed: N (no) | | | | | | |
| | (circled)Found | l on floorActivity at | | | | | | |
| | time of fall:Transferring self (indicated | | | | | | | |
| | by X)Safety eq | quipment in place and | | | | | | |
| | functioning at tin | me of incident? Y (Yes) | | | | | | |
| FORM CMS-2 | 567(02-99) Previous Version | ons Obsolete Event ID: | G2ED | 11 Facility l | D: 012355 | If continuation sh | eet Pa | ge 22 of 47 |

Page 22 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | A. BUILD | DING | NSTRUCTION 00 | (X3) DATE S COMPL 10/07/20 | ETED | |
|--|--|--|---------|---------------|--|----------|--------------------|
| | | 130702 | B. WING | | DDRESS, CITY, STATE, ZIP CODE | 10/07/20 | 511 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 814 S 67 | | | |
| | OAK HEALTH CAME | | | | ELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | , n | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | REFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| | | chair brakes locked? N | | | | | 21112 |
| | (circled)Prevention UpdateNonskid | | | | | | |
| | footwearCall bellTeach w/c | | | | | | |
| | safetyEnsure w | | | | | | |
| | _ | onal activitiesHip | | | | | |
| | protectors" Do | cumentation indicated the | | | | | |
| | IDT (interdiscipl | inary team) review was | | | | | |
| | done on 6/7/11. I | Documentation indicated | | | | | |
| | "IDT review of a | bove prevention update | | | | | |
| | | riate to maximize | | | | | |
| | safetyY (circle | d)Increase amount of | | | | | |
| | ` ′ | bulation & re-eval | | | | | |
| | (re-evaluate) in 2 | 2 weeks" | | | | | |
| | A resident care p | olan dated 3/3/11 was not | | | | | |
| | updated to indica | | | | | | |
| | ^ | es were locked, the use of | | | | | |
| | diversional activ | ities, and the use of hip | | | | | |
| | protectors after the | he 6/6/11 fall. | | | | | |
| | | 1.7/04/11 1.0.15 D.M. | | | | | |
| | | ated 7/24/11 at 8:15 P.M. | | | | | |
| | | ent found on floor beside | | | | | |
| | | nber). PJ (pajama) s, and brief pulled down | | | | | |
| | | nt states 'wanted to go | | | | | |
| | | Documentation was | | | | | |
| | | alarms being in place | | | | | |
| | and functioning. | , and this sering in place | | | | | |
| | | | | | | | |
| | A "Fall Circumst | tance Assessment and | | | | | |
| | Intervention" form dated 7/24/11 at 8:15 | | | | | | |
| | P.M. indicated ". | Witnessed: N (no) | | | | | |
| | (circled)Found | on floorActivity at | | | | | |
| | time of fall:Toil | leting (indicated by | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MU A. BUIL | | NSTRUCTION 00 | (X3) DATE (COMPL | ETED | |
|--|---|--|--------|---------------|--|---------|--------------------|
| | | 155782 | B. WIN | | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 814 S 6 | DDRESS, CITY, STATE, ZIP CODE | | |
| | OAK HEALTH CAMP | PUS | | | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| | slash). Wanted to | go to bathroomAlarm | | | | | |
| | off resident, pj bottoms pulled down to | | | | | | |
| | (indicated by arro | ow) knee along with | | | | | |
| | hipstersSafety | equipment in place and | | | | | |
| | | ne of incident? N | | | | | |
| | | ntion UpdateBed and/or | | | | | |
| | | l in low positionPlace | | | | | |
| | in recliner @ nur Documentation i | | | | | | |
| | | team) review was done | | | | | |
| | | imentation indicated | | | | | |
| | | bove prevention update | | | | | |
| | | riate to maximize | | | | | |
| | safetyY (circle | d)Placing in recliner @ | | | | | |
| | nurses station" | | | | | | |
| | A | 1 1 1 2 /2 /11 1 | | | | | |
| | - | lan dated 3/3/11 and 11 indicated "in | | | | | |
| | recliner after mea | | | | | | |
| | recinici unter met | | | | | | |
| | Nurses' notes ind | licated: | | | | | |
| | 9/6/11 at 10:30 A | A.M. "Res transferring s | | | | | |
| | | rom w/c to bed. Alarm | | | | | |
| | sounding off. Re | s was loosing (sic) | | | | | |
| | balance so this n | urse put her hands under | | | | | |
| | _ | her from falling then was | | | | | |
| | assisted to bed c (with) ii (two) assist" | | | | | | |
| | 9/6/11 at 5:00 P.M. "Resident's alarm | | | | | | |
| | (w/c) was sounding & CRCA went to assist & observed resident on the floor beside bed. Res had been trying to self | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | transfer from w/o | e to bed. W/C alarm on & | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G2ED11 Facility ID:

012355

If continuation sheet

Page 24 of 47

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 10/07/2011 | | |
|--|---|--|--|--------------|-------------------------------------|--|---------|--------------------|
| NAME OF E | PROVIDER OR SUPPLIER | · | | | ADDRESS, CITY, STA | TE, ZIP CODE | | |
| | | | | 814 S 6 | | | | |
| | OAK HEALTH CAM | PUS | | MONTIC | CELLO, IN47960 | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL | | ID PREFIX | (EACH CORRECTIVE CROSS-REFERENCE | AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE | E | (X5) COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFIC | CIENCY) | | DATE |
| | soundingRes s'bed.'" | tated 'I was going to | | | | | | |
| | A "Fall Circums Intervention" for P.M. indicated ". (circled)Found at time of fall:T (indicated by X) place and function Y (circled)Who (circled)Transfer bedPrevention footwearCall be safetyAlarming brakes are locked alarmDiversion added to w/c" the IDT (interdist was done on 9/7/2 indicated "IDT reprevention updated maximize safety A resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care pupdated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care) in the IDT (indicated "Resident care) in the IDT (indicated "IDT representation updated 9/7/11 in w/cw/c out of the IDT (indicated "Resident care) in the IDT (indi | Safety equipment in oning at time of incident? eelchair brakes locked? N ferring self to UpdateNonskid oellTeach w/c g seat beltEnsure w/c dBed and/or chair nal activitiesDicem (sic) Documentation indicated sciplinary team) review /11. Documentation eview of above te agrees as appropriate toY (circled)" olan dated 3/3/11 and indicated "dycem to reach" ated 9/24/11 at 4:30 P.M. ent observed on floor in uttocks c (with) back | | | | | | |
| | , , | door. 0 (no) nonskid | | | | | | |
| | | beside bed c (with) brakes | | | | | | |
| FORM | | sounding but was | | | D 6:55 | 10 | | |
| FORM CMS-2 | 567(02-99) Previous Version | ons Obsolete Event ID: | G2ED1 | 1 Facility I | D: 012355 | If continuation she | eet Pac | ge 25 of 47 |

| NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Muffled by pillow" A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated " Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by X)Improper or ill fitting footwear |
|--|
| WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Muffled by pillow" A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by |
| PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 (IN A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 (IN A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE APPROPRIATE DEFICIENCY) (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE APPROPRIATE DEFICIENCY) (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE APPROPRIATE DEFICIENCY) (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE APPROPRIATE DEFICIENCY) (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE APPROPRIATE DEFICIENCY) (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE APPROPRIATE DEFICIENCY) (IN A "FALL CIRCUMSTANCE ASSESSMENT AND THE |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Muffled by pillow" A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by |
| muffled by pillow" A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by |
| A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by |
| Intervention" form dated 9/24/11 at 4:30 P.M. indicated "Witnessed: N (no) (circled)Found on floor. YesActivity at time of fall:Ambulating (indicated by |
| (indicated by X)Safety equipment in place and functioning at time of incident? Y (circled)Wheelchair brakes locked? Y (circled)Bed alarm on & sounding. Resident had pillow on top of alarmPrevention UpdateNonskid footwearCall bellBed and/or chair alarm" Documentation indicated the IDT (interdisciplinary team) review was done on 9/26/11. Documentation was lacking to indicate additional recommendations after the 9/24/11 fall. A resident care plan dated 3/3/11 indicated documentation was lacking related to any additional interventions being implemented after the 9/24/11 fall. Review on 10/6/11 at 12:40 P.M. of a CNA assignment sheet provided by the Administrator indicated "Safety Risk F (falls)Alaerm (sic) box to bed at foot of |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | LDING | NSTRUCTION 00 | (X3) DATE COMPL 10/07/2 | ETED |
|--------------------------|---|---|---------------------|--|-------------------------------|----------------------|
| | PROVIDER OR SUPPLIER | | STREET A 814 S 6 | DDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | SUMMARY S' (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | intervention of wappropriate for the circumstance. She caused by the wholocked. She indicated in respect to the should be placed resident. She indicated to the use of diverse 5/30/11 fall. She was alert and tole the toilet so "toil needed." She indicated in the sure what is happed wasn't in her whole disappearing. She although it isn't was the sure were no ad | neelchair brakes not being cated the self releasing reacted the self releasing reacted. It was just a trial." She is the motion sensor had soom and the alarm box out of reach of the icated there should have boxes in the resident's steed there was no f increased ambulation or ional activities after the indicated the resident d staff when she needed eting program was not licated "we aren't really bening to the dycem. It | | | | |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | |
|------------|--|------------------------------|---------|------------|--|--------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155782 | B. WIN | G | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| TWINE OF I | NO VIDER OR SOIT EIEI | | | 814 S 6 | | | |
| WHITE (| OAK HEALTH CAMI | PUS | | MONTI | CELLO, IN47960 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | or Resident #23 was | F0 | 323 | Corrective actions accomplis for those residents found to | | 11/06/2011 |
| | reviewed on 10/0 | 05/11 at 12:45 p.m. | | | been affected by the alleged | | |
| | | | | | deficient practice:Interventions | | |
| | Diagnoses included, but were not limited to hip joint replacement, persistent mental | | | | have been implemented to | | |
| | | | | | prevnet falls following comp | | |
| | disorders due to | condition, hypertension, | | | of risk assessment for Residual #23 and #30Identification of | | |
| | anxiety, and sen | ile dementia | | | residents having t potential t | | |
| | uncomplicated. | | | | affected by the same alleged | | |
| | | | | | deficient practice and correct | | |
| | The facility Asse | essment Review and | | | actions taken:All residents | | |
| | Considerations of | lated 04/06/11 indicated, | | | assessed at risk for falls or residents who have fallen ha | | |
| | | has the following risk | | | been identified as having the | | |
| | factors that may | _ | | | potential to be affected. | | |
| | | condition/diagnosisAn | | | Interventions have been | | |
| | | are plan has been initiated | | | implemented to prevent falls | | |
| | | ove risk factors and | | | following completion of risk assessements. Measures pu | ıt into | |
| | | k of falling and/or reduce | | | place and systemic change | | |
| | the likelihood of | - | | | to ensure the alleged deficie | | |
| | l the fixelihood of | injury | | | practice does not recur:Eacl | | |
| | The admission N | Minimum Data Set (MDS) | | | admission is assessed for fa | ll risk | |
| | | ed 04/13/11 indicated | | | with approproate itervention intitiated for prevention. Follows | owing | |
| | Resident #23 had | | | | each fall the resident is asse | • | |
| | | | | | with interdisciplinary | - | |
| | • | e MDS indicated Resident | | | approach and intervention a | nd | |
| | | ented to year or day of the | | | care plan updated to reflect | | |
| | | ed "blue" and "bed" with | | | current interventions. How the corrective actions will be | ie | |
| | 1 | t #23's total cognitive | | | monitored to ensure the alle | ged | |
| | | t of a possible 15, | | | deficient practice does not | O = = | |
| | _ | sident was severely | | | recur:DHS or designee is | | |
| | | nitive decision-making | | | reviewing each new admissi | on for | |
| | skills. | | | | fall risk assessment and approproate interventon | | |
| | | ted Resident #23 was an | | | implemented as well as revi | ewing | |
| | | with two person physical | | | each resident's medical reco | - | |
| | | r and toilet use. The | | | following a fall for appropriat | | |
| | MDS indicated t | he resident was not | | | current interventions and up | dated | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | | LDING | NSTRUCTION 00 | | 3) DATE SURVEY COMPLETED 10/07/2011 |
|---------------|---|--|--|---------------|---|-------------------|---------------------------------------|
| NAME OF I | PROVIDER OR SUPPLIER | <u> </u> | | | DDRESS, CITY, STATE, ZI | IP CODE | |
| | | | | 814 S 6 | | | |
| | OAK HEALTH CAMI | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY | HE APPROPRIATE | COMPLETION DATE |
| 1710 | | n and off the toilet and | | 1710 | care plan. All mon | | |
| | required human assistance to stabilize. A care plan titled, "Falls," dated 04/20/11 | | | | will be reported ea QA committee x 7 | | |
| | | | | | review and evalua effectiveness. All of | | |
| | _ | sk for fall/injury AEB [as | | | | | |
| | evidenced by] H | | | | actions will be con 11/6/11. | - | |
| | | on usagepainResident | | | | | |
| | | d risk of fall related | | | | | |
| | injury by utilizin | ng precautionsUse fall | | | | | |
| | risk assessment t | to identify risk | | | | | |
| | factors_Report factors_ | alls to MD/responsible | | | | | |
| | | or side effects of any drug | | | | | |
| | that can cause ga | ait disturbance, orthostatic | | | | | |
| | | akness, sedation, vertigo, | | | | | |
| | _ | l statusReport to MD | | | | | |
| | • • | e effects associated with | | | | | |
| | | tion use_Provide | | | | | |
| | | daptations:Half rails as | | | | | |
| | enabler_Call lig | | | | | | |
| | | nonitor use of adaptive | | | | | |
| | devices:Wheel | chair" | | | | | |
| | A care plan title | d, "ADL [activities of | | | | | |
| | _ | f Care Deficit dated | | | | | |
| | " | ed, "Needs assistance or | | | | | |
| | is dependentTo | | | | | | |
| | is dependent I | JII 0 0 0 0 | | | | | |
| | A care plan titled | d, "Impaired cognitive | | | | | |
| | | /05/11 indicated Resident | | | | | |
| | · · · · · · · · · · · · · · · · · · · | problems and recall | | | | | |
| | problems related | to a diagnosis of | | | | | |
| | _ | ventions included, but | | | | | |
| | were not limited | to assess changes in | | | | | |
| | cognitive status | and conduct regular safety | | | | | |
| FORM CMS-2 | .567(02-99) Previous Version | ons Obsolete Event ID: | G2ED11 | Facility I | D: 012355 If | continuation shee | Page 29 of 47 |

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | LDING | nstruction 00 | (X3) DATE : COMPL 10/07/2 | ETED |
|---------------|--|--|--|---------------|--|---------------------------------|--------------------|
| NAME OF I | DDOMINED OF CLIRBS TER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | PROVIDER OR SUPPLIER | | | 814 S 6 | | | |
| WHITE C | OAK HEALTH CAME | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | 1 | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| TAG | checks. | LSC IDENTIF TING INFORMATION) | | IAG | , | | DATE |
| | checks. | | | | | | |
| | A care plan titled, "Impaired vision," | | | | | | |
| | dated 07/05/11 indicated, 'Legally blindDisease process (list):Macular | | | | | | |
| | | | | | | | |
| | degeneration" | | | | | | |
| | A Physical Thera | apy Progress Report dated | | | | | |
| | 1 | 04/22/11 to 04/29/11 | | | | | |
| | indicated, "Ski | lled PT [physical | | | | | |
| | therapy] is neces | sary to address balance | | | | | |
| | and safely in am | bulation to reduce risk for | | | | | |
| | falls." | | | | | | |
| | A Skilled Nursin | g Assessment and Data | | | | | |
| | | 04/23/11 indicated, | | | | | |
| | | n] memory deficits - | | | | | |
| | - | after 5 minutes" | | | | | |
| | | | | | | | |
| | A Skilled Nursin | g Assessment and Data | | | | | |
| | Collection dated | 04/28/11 indicated, | | | | | |
| | "Cognitive patter | rnsremains the same" | | | | | |
| | A | 4-104/20/11 -47-07 | | | | | |
| | | ted 04/28/11 at 7:05 p.m. | | | | | |
| | indicated, "wri | on the floor to [left] side | | | | | |
| | | RCA [certified resident | | | | | |
| | care aide] was pr | • | | | | | |
| | | for and] reported that | | | | | |
| | | II. CRCA stated that res | | | | | |
| | | o wipe self [sign for | | | | | |
| | | hifted weight on toilet | | | | | |
| | ' | floorStaff unable to | | | | | |
| | move ressevere | e [sign for left] hip pain." | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G2ED11 Facility ID: 012355

If continuation sheet

Page 30 of 47

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MI A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE : COMPL 10/07/2 | ETED | |
|--|--|--|-------|----------------|---|------|--------------------|
| | PROVIDER OR SUPPLIE | | | 814 S 6 | DDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN47960 | | |
| (X4) ID PREFIX | SUMMARY S | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | (X5) COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | A nurses note dated 04/28/11 at 7:50 p.m. indicated, "en (sic) route toER [emergency room]." | | | | | | |
| | Intervention form p.m. indicated respective or mereffects safety and question marked difficulty understanding or walk This question marked to maintage standing or walk This question marked to maintage standing or walk to maintage to complish the forgets." The present the toilet riser respectively. The present the fall care plant to the property of the fall care plant to the property of the fall care plant to the present th | ance, Assessment and m dated 04/28/11 at 7:05 esident fell in the CRCA was in the time of the fall. The fall nt questions included, but to, "Resident has mory impairment that d judgement?" This I "yes." "Resident has standing and following is question marked "no." es assistance to transfer?" arked "yes." "Resident is ain balance while sitting, sing without assistance?" arked "yes." "Resident by with safety measures at use, alarms, appliances, and marked "yes" with a cindicated, "often evention update indicated placed. No IDT by team] recommendations tervention to prevent falls. | | | | | |

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CL | IA (| X2) MUL | TIPLE CO | NSTRUCTION | | (X3) DATE | |
|------------|-----------------------------|---------------------------|------------|----------|------------|-------------------|--|-----------|-------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | 4 | A. BUILD | ING | 00 | | COMPL | |
| | | 155782 | | B. WING | | | | 10/07/2 | 011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | | DDRESS, CITY, STA | TE, ZIP CODE | | |
| | | | | | 814 S 6 | | | | |
| WHITE C | OAK HEALTH CAMP | PUS | | | MONTIC | CELLO, IN47960 |) | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | | ID | | LAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY F | | | REFIX | CROSS-REFERENCE | E ACTION SHOULD BE ED TO THE APPROPRIAT | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMA | ITION) | | TAG | DEFI | CIENCY) | | DATE |
| | | arge instruction sheet | | | | | | | |
| | | ndicated Resident #23 | | | | | | | |
| | had a left hip cor | ntusion. | | | | | | | |
| | | | | | | | | | |
| | | ated 06/10/11 at 1220 | , | | | | | | |
| | | icated, "Res has been c | o | | | | | | |
| | 1 | vere pain to [sign for | | | | | | | |
| | right] knee since | e last eveningRes hav | ing | | | | | | |
| | difficulty bearing | g weight on that knee | ." | | | | | | |
| | | | | | | | | | |
| | A nurses note da | ated 06/11/11 at 0500 | | | | | | | |
| | [5:00 a.m.] indic | cated Resident #23 | | | | | | | |
| | continues to have | e right knee pain. | | | | | | | |
| | | | | | | | | | |
| | A nurses note da | ated 06/12/11 at 1800 | | | | | | | |
| | [6:00 p.m.] indic | cated, "Ambulation | | | | | | | |
| | 1 2 | sign for right] knee pai | n." | | | | | | |
| | _ | | | | | | | | |
| | A nurses note da | ated 06/13/11 at 0400 | | | | | | | |
| | [4:00 a.m.] indic | cated, 'Res found on flo | or | | | | | | |
| | by CRCA states | attempting to get up ar | ıd | | | | | | |
| | slipped" | 1 0 0 1 | | | | | | | |
| | | | | | | | | | |
| | A Fall Circumsta | ance, Assessment and | | | | | | | |
| | | n dated 06/13/11 at 040 | 00 | | | | | | |
| | | eated Resident #23 fell | | | | | | | |
| | | attempting to transfer se | 1 | | | | | | |
| | | assessment questions | | | | | | | |
| | included, but we | - | | | | | | | |
| | · | ognitive or memory | | | | | | | |
| | | - | | | | | | | |
| | - | effects safety and | | | | | | | |
| | * * | is question marked "no |)." | | | | | | |
| | | fficulty understanding | | | | | | | |
| | and following di | rections?" This question | on | | | | | | |
| FORM CMS-2 | 567(02-99) Previous Version | ons Obsolete Ever | nt ID: G2E | ED11 | Facility I | D: 012355 | If continuation sh | neet Pa | ge 32 of 47 |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | | LDING | nstruction 00 | (X3) DATE COMPI 10/07/2 | LETED | |
|--|---------------------|--|-------|------------------|---|-------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIE | R | • | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | OAK HEALTH CAM | | | 814 S 6 | TH ST CELLO, IN47960 | | |
| | | | | <u> </u> | JELLO, IN47900 | | 210 |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B | | (X5) COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | RIATE | DATE |
| | marked "no." "I | Resident requires | | | | | |
| | | nsfer?" This question | | | | | |
| | marked "yes." " | | | | | | |
| | maintain balance | | | | | | |
| | walking without | assistance?" This | | | | | |
| | ^ | l "no." "Resident refuses | | | | | |
| | | safety measures such as | | | | | |
| | | arms, appliances, etc?" | | | | | |
| | ^ | arked "no." The | | | | | |
| | | te indicated resident was | | | | | |
| | | light usage. No IDT | | | | | |
| | | y team] recommendations | | | | | |
| | indicated. | | | | | | |
| | The "Fall" care i | plan was updated on | | | | | |
| | 1 | ded "hipsters" as an | | | | | |
| | intervention. | aca impoters as an | | | | | |
| | | | | | | | |
| | A nurses note da | ated 06/13/11 at 1830 | | | | | |
| | | cated, "Fall review res has | | | | | |
| | • | ninRes is SBA [stand by | | | | | |
| | | ambulation] [sign for | | | | | |
| | _ | just slipped off bed.' | | | | | |
| | Educated res on | using call light" | | | | | |
| | An MDS dated (| 07/03/11 indicated | | | | | |
| | | I severely impaired vision. | | | | | |
| | | ated Resident #23 did not | | | | | |
| | | t year, and recalled "blue" | | | | | |
| | | cueing. The total | | | | | |
| | | was an 8 out of a possible | | | | | |
| | _ | e resident was moderately | | | | | |
| | _ | nitive decision-making | | | | | |
| | skills. The MDS | S indicated the resident | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | (X2) MU A. BUIL B. WINC | DING | nstruction 00 | (X3) DATE (COMPL 10/07/2 | ETED |
|--|---|--|-------------------------------|---------------|--|---------------------------------|--------------------|
|),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | DROLUDED OF SUMPTON | <u> </u> | J. 171110 | | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | X. | | 814 S 6 | | | |
| | OAK HEALTH CAM | | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION DATE |
| TAG | | LSC IDENTIFYING INFORMATION) | | IAG | BEIGHACI | | DATE |
| | _ | n physical assist to | | | | | |
| | transfer and toilet. The MDS indicated Resident #23 was not steady and needed human assistance to stabilize to do activities such as moving on and off toilet. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | A Physical Thera | apy Discharge Summary | | | | | |
| | | ndicated Resident #23's | | | | | |
| | current level of f | unctioning was | | | | | |
| | independent with | n transfers with a | | | | | |
| | moderate fall ris | k. The discharge | | | | | |
| | summary indicat | ed the resident was | | | | | |
| | oriented with con | nfusion. | | | | | |
| | | . 107/10/11 | | | | | |
| | | ted 07/19/11 at 0940 | | | | | |
| | [9:40 a.m.] indic | • | | | | | |
| | | 'the secret service are out | | | | | |
| | to get usorder | for UA [urinalysis]" | | | | | |
| | A nurses note da | ted 08/03/11 at 3:15 p.m. | | | | | |
| | indicated a medi | • | | | | | |
| | discontinued per | the doctor due to the | | | | | |
| | resolution of the | diagnosis for the | | | | | |
| | medicine and po | ssible side effects. | | | | | |
| | | | | | | | |
| | | ing Assessment & Data | | | | | |
| | | dated 08/05/11 indicated | | | | | |
| | | ependent with toileting. | | | | | |
| | | ted Resident #23 was | | | | | |
| | | The form indicated the | | | | | |
| | _ | nitive impairment that | | | | | |
| | 1 | d judgement, and the | | | | | |
| | | -compliant with safety | | | | | |
| | measures. The f | form indicated the resident | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | | (X3) DATE SURVEY COMPLETED 10/07/2011 | | |
|--|--|---|-------|---------------|--------------------|---|--------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIEF | ? | | | ADDRESS, CITY, STA | TE, ZIP CODE | | |
| | | | | 814 S 6 | | | | |
| | OAK HEALTH CAMI | | | MONTIC | CELLO, IN47960 | | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID | | AN OF CORRECTION E ACTION SHOULD BE | | (X5) |
| TAG | * | ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCEI | D TO THE APPROPRIAT CIENCY) | E | COMPLETION DATE |
| | | ace to ambulate and | | | | | | |
| | transfer. | | | | | | | |
| | [9:00 a.m.] indice res laying on her floor. Res stated walker and walk very tearfultail wet as well as hed bed wet. When a res stated, 'yes, I | atted 09/19/11 at 0900 cated, "CRCAfound back on the bathroom d, 'I forgot to get my ded in here without itres lbone painRes bed was er hipsters were lying on asked if she took them off had to they are led tohospital ER." | | | | | | |
| | A nurses note da [11:40 a.m.] indi | ated 09/19/11 at 1140 icated, "Res returned from for no] new orders" | | | | | | |
| | 09/19/11 at 0900 "Res transferred bathroom [sign of self" The fall questions include to, "Resident has impairment that judgement?" The "Resident has did and following did marked "no." "Fassistance to transmarked "no." "Fassistance" in the control of the | nsfer?" This question Resident is unable to | | | | | | |
| | | e while sitting, standing or assistance?" This | | | | | | |
| FORM CMS-2 | 567(02-99) Previous Version | | G2ED1 | Facility I | ID: 012355 | If continuation sh | eet Pa | ge 35 of 47 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | | ULTIPLE CO LDING | INSTRUCTION 00 | (X3) DATE COMPL | | |
|--|---|------------------------------|---------------------|----------------|---|---------|------------|
| | | 155782 | B. WIN | | | 10/07/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | } | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 814 S 6 | | | |
| WHITE C | DAK HEALTH CAMI | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | <u> </u> | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | • | "no." "Resident refuses | | | | | |
| | to comply with safety measures such as | | | | | | |
| | call light use, alarms, appliances, etc?" | | | | | | |
| | This question marked "yes." The | | | | | | |
| | prevention update indicated, "teach w/c | | | | | | |
| | | etyeducation on | | | | | |
| | * | /c and walker use" No | | | | | |
| | IDT recommend | ations indicated. | | | | | |
| | | | | | | | |
| | ^ | plan update on 09/19/11 | | | | | |
| | indicated, "education on Res using | | | | | | |
| | walker." | | | | | | |
| | | | | | | | |
| | | 0:55 a.m. Resident #23 | | | | | |
| | · · | ying on her bed with her | | | | | |
| | _ | e resident's wheelchair | | | | | |
| | - | t the foot of the resident's | | | | | |
| | bed. | | | | | | |
| | | | | | | | |
| | _ | riew on 10/06/11 at 10:56 | | | | | |
| | • | Resident Care Aide | | | | | |
| | , , , , , | licated Resident #23 | | | | | |
| | | from bed to wheel chair | | | | | |
| | | CRCA #2 indicated the | | | | | |
| | | or assistance if the | | | | | |
| | | eeded changed, otherwise | | | | | |
| | | assistance. CRCA #2 | | | | | |
| | | ident has poor vision and | | | | | |
| | "can't see her wa | itch." | | | | | |
| | | | | | | | |
| | _ | iew on 10/06/11 at 10:57 | | | | | |
| | • | dicated Resident #23 was | | | | | |
| | | t of 1 on the daily | | | | | |
| | assignment shee | t under mobility. | | | | | |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE COMPL | |
|-----------|---|---|--------|------------|--|--------------------|------------|
| AND PLAN | OF CORRECTION | 155782 | | LDING | 00 | 10/07/2 | |
| | | 100702 | B. WIN | | DDDEGG CITY OTATE TID CODE | 10/01/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | 814 S 6 | ADDRESS, CITY, STATE, ZIP CODE | | |
| WHITE C | OAK HEALTH CAME | PUS | | | CELLO, IN47960 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 010/06/111 | 2.40 mm 41 mF mm 45 m | | | | | |
| | | 2:40 p.m., the Executive | | | | | |
| | _ | d the daily assignment at #23 for 10/06/11. | | | | | |
| | slieet for Resider | 11 #25 101 10/00/11. | | | | | |
| | The daily assignment sheet dated | | | | | | |
| | , , , | 5 a.m. indicated resident | | | | | |
| | | t of 1 for mobility. | | | | | |
| | | | | | | | |
| | During an interview on 10/06/11 at 1:40 | | | | | | |
| | p.m., the Director of Health Services | | | | | | |
| | (DHS) indicated she assisted the CRCA | | | | | | |
| | _ | ut Resident #23 on the | | | | | |
| | | ated the toilet riser was | | | | | |
| | | ated documentation does | | | | | |
| | 1 | et when two person | | | | | |
| | | ts are used. DHS | | | | | |
| | | ervention was to replace | | | | | |
| | | t it down. She indicated | | | | | |
| | | was not reflected on the | | | | | |
| | | e it was environmental. | | | | | |
| | | Resident #23 was taking | | | | | |
| | | DHS indicated, "She way." DHS indicated | | | | | |
| | 1 | ent reminders and | | | | | |
| | | o use walker and call | | | | | |
| | light. | o and warker and can | | | | | |
| | | | | | | | |
| | A policy provide | ed by the DHS on | | | | | |
| | 1 2 1 | p.m. titled, "Fall/Safety | | | | | |
| | | ucational Information," | | | | | |
| | | ves to maintain a hazard | | | | | |
| | free environmen | t, mitigate fall risk factors | | | | | |
| | and implement p | reventative | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | A. BUI | LDING | NSTRUCTION 00 | (X3) DATE COMPI 10/07/2 | ETED |
|-----------|--|--|--------|---------|---|-------------------------------|------------|
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 1 .5,5,72 | |
| NAME OF F | PROVIDER OR SUPPLIER | t | | 814 S 6 | | | |
| WHITE C | OAK HEALTH CAME | PUS | | | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | all Circumstance and | | | | | |
| | | orm'includes the | | | | | |
| | , | sic) of the circumstances | | | | | |
| | _ | fall to determine the | | | | | |
| | • | ode, a reassessment to | | | | | |
| | | contributing factors, | | | | | |
| | | reduce risk of repeat | | | | | |
| | episode and a rev | view by the IDT | | | | | |
| | [interdisciplinary | team] to evaluate | | | | | |
| | thoroughness of | the investigation and | | | | | |
| | appropriateness | of the | | | | | |
| | interventionsNurse caring for a resident | | | | | | |
| | at the time of a fa | all will initiate | | | | | |
| | investigation into | o cause of the fall. It is | | | | | |
| | imperative to dis | cover, 'what the resident | | | | | |
| | _ | at the time of the fall.'If | | | | | |
| | | as been tried, but falls | | | | | |
| | still occur, move | , , , , , , , , , , , , , , , , , , , | | | | | |
| | · · | rior one has not been | | | | | |
| | _ | entions should be | | | | | |
| | | me a 'risk' is identified, | | | | | |
| | | all occurs" The policy | | | | | |
| | | e interventions for least | | | | | |
| | • | rately restrictive and | | | | | |
| | highest restrictiv | | | | | | |
| | ingliest restrictiv | С. | | | | | |
| | 3.1-45(a)(2) | | | | | | |
| | 3.1-43(a)(2) | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | A. BUILDING 00 | | (X3) DATE SURVEY COMPLETED 10/07/2011 | |
|--|--|---|---------------------|--|---------------------------------------|--|
| | PROVIDER OR SUPPLIE | | 814 S 6 | ADDRESS, CITY, STATE, ZIP CODE STH ST CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| F0325 SS=D | assessment, the resident - (1) Maintains acconstritional status, protein levels, unle condition demonstrates possible; and (2) Receives a the anutritional problem Based on observations were prevent weight 1 for 1 of 3 resides sample of 10. (Receives a the interventions were prevent weight 1 for 1 of 3 resides sample of 10. (Receives a the interventions were prevent weight 1 for 1 of 3 resides sample of 10. (Receives a the interventions were prevent weight 1 for 1 of 3 resides sample of 10. (Receives a the interventions were prevent weight 1 for 1 of 3 resides sample of 10. (Receives a the interventions were prevent weight 1 for 1 of 3 resides sample of 10. (Receives a the interventions were prevent weight 1 for 1 of 3 resides a the interventions were prevent weight 1 for 1 of 3 resides and 10 for | ration, interview, and e facility failed to ensure ere implemented to oss related to supplements ints with weight loss in a desident #3). | F0325 | Corrective actions accomplis for those residents found to been affected by the alleged deficient practice:Intervention help ensure that Resident #3 maintains acceptable param of nutritional status have beer eviewed an implemented per dietitian recommendations, physician orders and resider preferences related to supplements. Identification of other residents having the potential to be affected by the same alleged deficient practical and corrective actions taken residents assessed with the | ns to Beters en er of ee eice | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G2ED11 Facility ID:

012355 If continuation sheet

Page 39 of 47

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | A. BUI | LDING | NSTRUCTION 00 | , , | SURVEY LETED 2011 |
|--------------------------|--|---|--------|---------------------|---|--|-------------------------|
| | | 100702 | B. WIN | | | 10/01/2 | 2011 |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | 814 S 6 | | | |
| WHITE C | DAK HEALTH CAMI | PUS | | MONTIC | CELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE | (X5) COMPLETION DATE |
| IAG | | , | | IAG | | | DATE |
| | observed lying in the bed elevated table across the laws on the overhouse eating his layed liquid on the resident as "his judding on the tabove observed shakes two times." On 10/5/11 at 9: Resident #3 was bed with an over The resident was There was a pinal container on his identified by LP. There was no puindicated the restortified pudding indicated "dietar do." On 10/5/11 at 10 was weighed by The resident's was weighed by The resident's was no puindicated." | 50 P.M. Resident #3 was in his bed with the head of a There was an overbed bed. The resident's tray bed table and the resident such. There was a glass of tray, identified by the uice." There was no ray. There was no ray. | | | potential to be at risk for maintaining acceptable parameters ofnutritional shave the potential to be a related to supplements. Tresidents have been revie and interventions implem per dietitian recommendate physician orders and resipreferences as approprial Measures put into place a systemic changes made ensure the alleged deficie pracitice does not recur: Supplement orders been placed on Medication Administration Record to supplents are administered physician order as well as percentage of intake of experiences. Dining services responsible for serving for pudding with meals and linurses will document per of pudding eaten by reside the meals licensed will ensure resident receipudding and document percentage eaten. How the corrective measures will monitored to ensure the adeficient pracitice does not recur: DHS or designee with Medication Administration and intake weekly x 7 months theread | ffected hese ewed ented tions, dent ie. and o ent have ensure ed per s ach o longer o will be rtified censed centage net on d nurses ves the ele ele ele ele ele ele ele ele ele e | |
| | Resident #3 8 CII | incai iecolu was ieviewed | | | | | |

012355

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | | ULTIPLE CO LDING | NSTRUCTION 00 | (X3) DATE : COMPL | ETED | |
|--|---|---|---------------------|--|--|----------------|--------------------|
| | | 155782 | B. WIN | | | 10/07/2 | 011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| WHITE C | OAK HEALTH CAMF | 2110 | | 814 S 6 | CELLO, IN47960 | | |
| | | | | <u>. </u> | | 1 | (7/5) |
| (X4) ID | | TATEMENT OF DEFICIENCIES CV MUST BE PERCEDED BY FULL | | ID PREEIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | DATE |
| PREFIX TAG | on 10/4/11 at 1:0 indicated the resident diagnoses which limited to, anemi malnutrition, and platelet count). Tresident had falled on the floor for the multiple pressured coccyx. A Minimum Data Assessment date resident was coglimited one-person eating, had an adpounds, and had A resident care prindicated "Resident was coglimited one-person eating, and had are pounds, and had are pounds, and had be a resident care prindicated "Resident care prin | dent was admitted with included, but were not a, protein calorie I thrombocytopenia (low the record indicated the en at home and had laid wo days resulting in e ulcers on back and a Set (MDS) Admission de 9/5/11 indicated the initively intact, required on physical assistance for mission weight of 118 no weight loss. Idan dated 9/1/11 ident at nutrition risk ed by)multiple wounds | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | orted e for | COMPLETION DATE |
| | 1 1 | eckmark)Administer | | | | | |
| | l ` • | rt as orderedVitamin | | | | | |
| | ` ` | cated by checkmark), | | | | | |
| | Supplements (inc | • | | | | | |
| | · · · · · · · · · · · · · · · · · · · | acks offer TID (three | | | | | |
| | times a day) (ind | • | | | | | |
| | / | fer substitutes if 50% or | | | | | |
| | less is consumed | (indicated by | | | | | |
| | checkmark)" | | | | | | |
| | | | | | | | |

| NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" STREET ADDRESS, CITY, STATE, ZIP CODE 814 8 6 TH ST THE MONTICELLO, IN47960 (X5) COMPLETION DATE TAG PROVIDER PLAN OF CORRECTION (X5) COMPLETION DATE ID PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE (X5) COMPLETION DATE TAG PROVIDER PLAN OF CORRECTION (CS) COMPLETION DATE A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 10/07/2 | ETED |
|--|-----------|---|--|--|--------|-----------------------------------|-------------------------------|------|
| WHITE OAK HEALTH CAMPUS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" 814 S 6TH ST MONTICELLO, IN47960 (X5) PREFIX TAG PREVIX TAG PREFIX TAG PREVIX TAG PREFIX TAG PREVIX TAG PREFIX TAG PREVIX TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETION DATE | NAME OF F | DROWNER OF GUIDE TER | <u> </u> | | | DDRESS, CITY, STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | | | | | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | WHITE C | OAK HEALTH CAME | PUS | | MONTIC | CELLO, IN47960 | | |
| A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | | | | PROVIDER'S PLAN OF CORRECTION | | |
| A physician's orders recapitulation dated October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | | | | CROSS-REFERENCED TO THE APPROPRIA | TE | |
| October 2011 indicated "8/29/11 Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | TAG | · · · · · · · · · · · · · · · · · · · | | | IAG | DEFICIENC1) | | DATE |
| Lactose Free Mighty Shakes 3 times a day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | • | | | | | |
| day8/31/11 Juven or House Equivalent to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | | | | | | |
| to aid in wound healing9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | | | | | | |
| Fortified Pudding to breakfast and supper as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | - | • | | | | | |
| as dessert9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | • | | | | | |
| Fortified Pudding to lunch as dessert240 ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | · | | | | | | |
| ml super shakes 3 times a day between meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | , | | | | | |
| meals duplicate order9/29/11 Enlive Supplement i (one) container TID" | | | _ | | | | | |
| Supplement i (one) container TID" | | meals duplicate order9/29/11 Enlive | | | | | | |
| | | | | | | | | |
| | | Nurses' notes dated 9/18/11 at 10:00 P.M. | | | | | | |
| Nurses' notes dated 9/18/11 at 10:00 P.M. | | | | | | | | |
| indicated "Resident also accuses nurses | | indicated "Res | ident also accuses nurses | | | | | |
| of lying (sic) to him about his Super | | of lying (sic) to l | nim about his Super | | | | | |
| Shake for each meal - states the 'last nurse | | Shake for each n | neal - states the 'last nurse | | | | | |
| said she put it in refrigerator because she | | said she put it in | refrigerator because she | | | | | |
| made it ahead of time & now no one can | | | time & now no one can | | | | | |
| find it." | | find it.'" | | | | | | |
| | | | B' 1 T 1' ' 1 1 | | | | | |
| A "Clinically at Risk Individual | | | | | | | | |
| Monitoring Sheet" indicated: | | Monitoring Shee | er indicated: | | | | | |
| 9/7/11 "Adm (admission) wt (weight) | | 9/7/11 " Adm (| admission) wt (waight) | | | | | |
| 117" | | ` | admission) wi (weight) | | | | | |
| 9/15/11 "Resident continues with | | | ent continues with | | | | | |
| weight instabilityWt 112Appetite fair. | | | | | | | | |
| Is a picky eater" | | | | | | | | |
| 9/21/11 "Resident continues with | | | | | | | | |
| weight instability. Nutritional | | | | | | | | |
| interventions in placeWt 109" | | | , | | | | | |
| 9/29/11 "Wt 108. Res will not drink 2 | | | • | | | | | |
| cal (calorie) or dairy products. Enlive | | | | | | | | |
| (juice-like product) et is accepting super | | · · · | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G2ED11 Facility ID: 012355

If continuation sheet

Page 42 of 47

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782 | | LDING | NSTRUCTION 00 | | DATE SURVEY COMPLETED 0/07/2011 |
|--------------------------|--|---|---------|---------------------|--|------|---------------------------------|
| | PROVIDER OR SUPPLIER | | D. WIIN | STREET A 814 S 6 | DDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN47960 | 3 | |
| (X4) ID PREFIX TAG | SUMMARY S' (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | shakes made c (v A "Nutrition Ass Collection" form the dietitian indic to add fortified p dessertRecomm super shakes TII recommend to ac order" A "Medication A dated September "Lactose Free I day (Nursing to a review indicated Documentation I shake had been g The resident com shake 37 out of 9 There was no do | sessment and Data dated 9/1/11 signed by cated "Will recommend budding at each meal as a mend 240 ml (milliliters) between mealsWill dd fortified foods to diet administration Record" 2011 indicated Mighty Shakes 3 times a make & give)" Further acking to indicate the given 10 out of 90 times. sumed 50% or less of the | | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR | D BE | |
| | The resident refu of 90 times. Documentation v Juven or House I pudding being gi A "Medication A dated October 1- | was lacking related to the Equivalent or the fortified iven. Administration Record" 4, 2011 indicated ighty Shakes 3 times a | | | | | |

012355

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MU A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE COMPL 10/07/2 | ETED | |
|--|---|--|---------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIED | | <u></u> | STREET A 814 S 6 | ODDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN47960 | • | |
| | | | | l | JELLO, 11147900 | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | dayJuven or H wound healing indicated docum related to the Juv being given. Review of a diet indicated "Super & powdered mil Documentation fortified pudding foods being prov Meal intake shee 10/3/11 indicate Breakfast: The r less of his meal documentation of offered; there wo meal intake two Morning Snack: documentation of offered 22 times Lunch: The resid less of his meal documentation of | ouse Equivalent to aid in "Further review bentation was lacking wen or House Equivalent secand dated 10/4/11 Shake made with water kbetween meals TID" was lacking related to g for desserts or fortified wided. ets dated 9/4/11 through desident consumed 50% or once with no of a substitute being as no documentation of times. There was no of a morning snack being dent consumed 50% or once with no of a substitute being as no documentation of a substitute being dent consumed 50% or once with no of a substitute being as no documentation of | | | | | |
| | Afternoon Snack documentation of | x: There was no of an afternoon snack | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE S | | |
|--|--|-----------------------------|---------|---------------|---|----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLE | |
| | | 155782 | B. WIN | G | | 10/07/20 | 11 |
| NAME OF F | PROVIDER OR SUPPLIEI | } | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 814 S 6 | | | |
| WHITE OAK HEALTH CAMPUS | | | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | I ` | | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE. | COMPLETION DATE |
| TAG | rag REGULATORY OR LSC IDENTIFYING INFORMATION) being offered 24 times. | | + | TAG | Dir lettere 17 | | DATE |
| | being offered 24 | times. | | | | | |
| | Dinner The resi | dent consumed 50% or | | | | | |
| | less of his meal | | | | | | |
| | | of a substitute being | | | | | |
| | | as no documentation of | | | | | |
| | meal intake 5 tir | | | | | | |
| | mear make 5 til | nes. | | | | | |
| | HS (hedtime) S | Snack: There was no | | | | | |
| | ` ′ | of a bedtime snack being | | | | | |
| | offered 26 times. A dietary note dated 9/22/11 indicated | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | "Wt 108# - do | | | | | | |
| | | wt loss in less than 30 | | | | | |
| | days" | Wt 1033 III 1033 than 30 | | | | | |
| | days | | | | | | |
| | A CNA assionm | ent sheet provided by the | | | | | |
| | | n 10/6/11 at 12:40 P.M. | | | | | |
| | | er shakes with meals" | | | | | |
| | maroutesup | or browness with mountain. | | | | | |
| | Interview on 10/ | 4/11 at 2:25 P.M. with | | | | | |
| | | Sursing indicated there | | | | | |
| | | ntation of the Juven being | | | | | |
| | | ated she thought the | | | | | |
| | ~ | re documented on the | | | | | |
| | meal intake shee | | | | | | |
| | | | | | | | |
| | Interview on 10/ | 75/11 at 9:50 A.M. with | | | | | |
| | | ager indicated the resident | | | | | |
| | 1 | g super shakes three times | | | | | |
| | | neals. She indicated to | | | | | |
| | 1 | tter was added to | | | | | |
| | 1 | ereal. She indicated Super | | | | | |
| | 1 5 - 1 a c c c c c c c c c c c c c c c c c c | Sur maioutou bupoi | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MU A. BUIL | | NSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|---|--|---------|---------------|--|---------|--------------------|
| | | 155782 | B. WING | | | 10/07/2 | 011 |
| NAME OF F | PROVIDER OR SUPPLIER | | • | STREET A | DDRESS, CITY, STATE, ZIP CODE | • | |
| | | | | 814 S 6 | | | |
| | OAK HEALTH CAMF | | | MONTIC | CELLO, IN47960 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | · · | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| 1710 | Shakes and Mighty Shakes were the same. | | | 1110 | | | DITTE |
| | "The company uses Super Shakes." She | | | | | | |
| | | ive was provided by | | | | | |
| | | sing makes the shakes." | | | | | |
| | | C | | | | | |
| | Interview on 10/0 | 6/11 at 10:30 A.M. with | | | | | |
| | the Registered D | ietitian indicated the | | | | | |
| | _ | nd Super Shakes were the | | | | | |
| | same. She indica | ted fortified foods | | | | | |
| | consisted of adding butter to oatmeal and mashed potatoes. If those foods were not on the menu, the fortified pudding was | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | used as fortified foods. She indicated the | | | | | | |
| | _ | ere being used as Juven. | | | | | |
| | | f the protein content was | | | | | |
| | the same. | | | | | | |
| | | 11 at 1:10 P.M. of a | | | | | |
| | | d procedure dated 12/07, | | | | | |
| | - | Director of Nursing, | | | | | |
| | | ent, and titled "High Risk | | | | | |
| | | ted "High Nutritional | | | | | |
| | | ignificant weight loss: | | | | | |
| | | .5% in 90 daysDx | | | | | |
| | . • . | nutritionprotein calorie | | | | | |
| | - | essure soresTwo ounces | | | | | |
| | | timeters]) Two Cal HN or | | | | | |
| | ^ ~ | caloric product is to be | | | | | |
| | | mined residents daily by | | | | | |
| | _ | each routine medication istration of prescribed | | | | | |
| | _ | istration of prescribed icked on the MAR | | | | | |
| | | inistration record) as is | | | | | |
| | ` | sNurses should record | | | | | |
| | omer medication | 5 varses silvala record | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782 | | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION 00 | | E SURVEY LETED 2011 | |
|--|----------------------|---|---------------------|--|---------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | STREI 814 S | ET ADDRESS, CITY, STATE, ZIP CODE S 6TH ST ITICELLO, IN47960 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| TAG | | LISC IDENTIFYING INFORMATION) LIMED ON THE MAR" | TAG | DEFICIENCY) | | DATE |